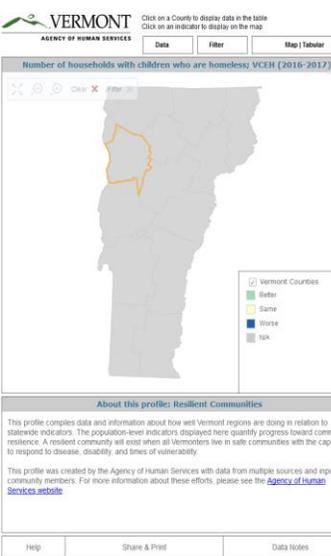


# ACH DATA DASHBOARDS

ACH Learning Lab

October 8, 2018

Why another dashboard?



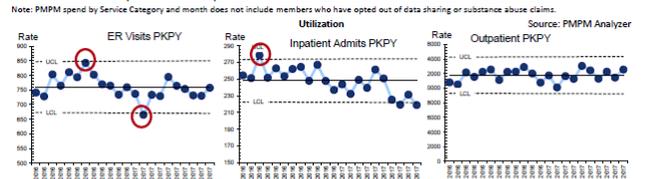
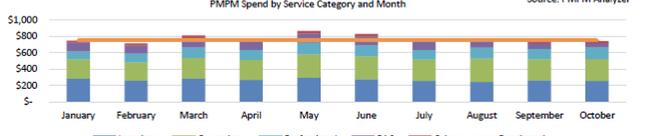
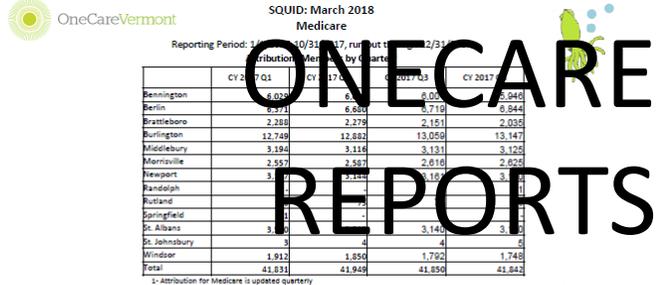
Indicator	County	County Value	Vermont Value	Statistical Comparison and Indicator Range for All Vermont Counties
<b>Basic Needs</b>				
Number of households with children who are homeless, YCCH (2016-2017)	Chittenden	40	169	0
Average number of public transit trips per resident per year, AOT/GMT, (2016)	Chittenden	15.6	7.5	1.2
<b>Healthy Development</b>				
Percent of pregnancies that are intended, PRAMS and Vital Statistics, (2014)	Chittenden	Data not available by County, DO, or HSA	52	No Data
Percent of children receiving childcare subsidies who are enrolled in 3, 4, or 5 STAR programs, DCF-CDO, Digital Futures Information System (DFIS), (2017)	Chittenden	63	51	1
Percent of children age 1-5 who have elevated blood lead levels (>5 ppb), VT Lead Database, (2013-2015)	Chittenden	-	-	-
Percent of kindergarten ready for school in all five domains of healthy development, ACE, (2017)	Chittenden	84	No Data	No Data
Rate of Children under the age of 18 in DCF Custody per 1,000 Vermont Children, AFORSYS Foster Care Detail Data Collection (4/1/16-9/30/16)	Chittenden	7.4	14.2	7
<b>Safety</b>				
Fall-related death rate per 100,000	Chittenden	-	-	-

# AHS High School Results: Table of Contents

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- Resilience



## BARRE HEALTH DISTRICT – 2016-2016 BRFS\$ DATA

Health Status Indicators	Barre	Vermont
General Health Status is Fair or Poor	5,000 11%	13%
Have Personal Health Care Provider	40,000 89%	88%
Have Health Insurance, Ages 18-64	32,000 93%	94%
Did Not Visit Doctor Due to Cost, in Last Year	4,000 8%	8%
Poor Physical Health <sup>2</sup>	5,000 12%	11%
Poor Mental Health <sup>2</sup>	5,000 11%	12%
Disabled <sup>2</sup>	11,000 25%	23%

## Preventative Behaviors and Health Screening

	Barre	Vermont
Flu Shot in the Last Year, Ages 65+	7,000 64%	59%
Pneumococcal Vaccine, Ever, Ages 65+	40,000 80%	77%
Routine Doctor Visit, in Last Year	31,000 70%	70%
Dental Visit in Last Year*	33,000 74%	71%
Any Teeth Extracted, Ages 45-64	9,000 49%	49%
Cholesterol Screened, in Last Five Years*	35,000 78%	76%
Ever Tested for HIV	16,000 39%	37%
2+ Daily Fruit Servings*	13,000 35%	32%
3+ Daily Vegetable Servings*	9,000 20%	20%
5+ Daily Fruit & Vegetable Servings*	10,000 23%	20%
Met Physical Activity Recommendations <sup>10</sup>	27,000 62%	59%
Met Strength Building Recommendations <sup>10</sup>	14,000 32%	30%
Use Community Resources for Physical Activity	26,000 58%	58%
Breast Cancer Screening, Women 50-74 <sup>10</sup>	8,000 79%	79%
Cervical Cancer Screening, Women 21-65 <sup>10</sup>	11,000 89%	86%
Colorectal Cancer Screening, Ages 50-75 <sup>10</sup>	14,000 75%	72%

## BARRE HEALTH DISTRICT – 2016-2016 BRFS\$ DATA

Risk Behaviors	Barre	Vermont
Adverse Childhood Experiences (ACE) Four or More <sup>2</sup>	6,000 13%	8%
Binge Drinking, in Last Month <sup>2</sup>	8,000 18%	18%
Heavy Drinking, in Last Month <sup>2</sup>	4,000 9%	9%
Marijuana Use, in Last Month <sup>2</sup>	7,000 15%	12%
Prescription Drug Misuse, Ever <sup>2</sup>	4,000 10%	7%
Smoke Cigarettes, Currently <sup>2</sup>	6,000 15%	18%
Made Quit Attempt in Last Year*	4,000 60%	51%
Use Smokeless Tobacco, Currently	1,000 2%	3%
No Leisure Time Physical Activity*	9,000 18%	18%
Seldom or Never Use Seatbelt	2,000 4%	4%

## Disease Prevalence

	Barre	Vermont
Arthritis, Ever Diagnosed	13,000 29%	28%
Asthma, Current Diagnosis	4,000 10%	10%
Cancer Diagnosis, Ever		
Skin Cancer	3,000 7%	7%
Non-Skin Cancer	3,000 7%	6%
High Cholesterol, Ever Diagnosed	15,000 40%	34%
Chronic Obstructive Pulmonary Disease, Ever Diagnosed	3,000 6%	6%
Cardiovascular Disease, Ever Diagnosed <sup>2</sup>	4,000 8%	8%
Depressive Disorder, Ever Diagnosed	12,000 26%	22%
Diabetes, Ever Diagnosed	3,000 8%	9%
Hypertension, Ever Diagnosed*	15,000 29%	25%
Overweight, Ages 20+	14,000 34%	34%

# BLUEPRINT for Health

Welcome to the *Blueprint for Health* Hospital Service Area (HSA) Profile. From the *Blueprint for Health*, a state-wide initiative transforming the way that we care and improve lives, these services are delivered in Vermont. The blueprint is leading a transformation in Vermont's health care system to be seamless, effective, and preventive health services.

*Blueprint HSA Profiles* are based primarily on data from Vermont's all-payer claims database, the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members attributed to Blueprint practices that began participating on or before June 30, 2017.

*Blueprint HSA Profiles* for the adult population cover members ages 18 years and older; pediatric profiles cover members between the ages of 1 and 17 years. Practices have been rolled up to the HSA level.

Utilization and expenditure rates presented in these profiles have been risk adjusted for demographic and health status differences among the reported populations.

These profiles use three key sources of data: VHCURES, the Blueprint clinical data registry, and the Behavioral Risk Factor Surveillance Study (BRFSS), a telephone survey conducted annually by the Vermont Department of Health.

This reporting includes only members with a visit to a primary care physician, as identified in VHCURES claims data, during the current reporting year or the year prior. Rates for HSAs reporting fewer than 30 members for a measure are not presented in alignment with NQCA HEDIS guidelines.

Demographics / Health	Cost of Care	Utilization	Preventive Care / ACO	BRFSS	Data Detail
Demographics & Health Status					
Average Members	6,312				
Average Age	53.2				
Female	50%				
Medicare	25%				
% Medicaid	37.0	34.1			
% Maternity	8.1	7.1			
% with Selected Chronic Conditions	40.4	43.1			
Diagnosed with (CRG)					
% Healthy	56.7				
% At Risk or Mild Chronic	41.8	14.7			
% Moderate Chronic	27.3	26.7			
% Significant Chronic	29.0	31.0			
% Cancer or Catastrophic	2.2	2.2			

## Community Health Needs Assessment

This table provides comparative information on the demographics and health status of the specified HSA and of the state as a whole. Included measures reflect the types of information used to generate adjusted rates: age, gender, maternity status, and health status.

Average Members serves as this table's denominator and adjusts for partial lengths of enrollment during the year. In addition, special attention has been given to adjusting for Medicaid and Medicare. This includes adjustment for each member's enrollment in Medicaid or Medicare; the member's HSA percentage of membership that was Medicaid or Medicare; Medicare disability or end-stage renal disease status; and the degree to which the member required special Medicaid services that are not found in commercial populations (e.g., day treatment, residential treatment, case management, school-based services, and transportation).

The % with Selected Chronic Conditions measure indicates the proportion of members identified through the claims data as having one or more of seven selected chronic conditions: asthma, chronic obstructive pulmonary disease, congestive heart failure (CHF), coronary heart disease, hypertension, diabetes, and depression.

The Health Status (CRG) measure aggregates 31<sup>11</sup> Clinical Risk Group (CRG) classifications for the year for the purpose of generating adjusted rates. Aggregated risk classification groups include: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic (e.g., minor chronic joint pain), Moderate Chronic (e.g., diabetes), Significant Chronic (e.g., diabetes and CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (e.g., HIV, muscular dystrophy, cystic fibrosis). CRG identification was enhanced using additional diagnostic and pharmacy information for 2020 reporting, resulting in fewer healthy members and more members with chronic and other conditions.



# COMMUNITY HEALTH NEEDS ASSESSMENT

**Executive Summary**

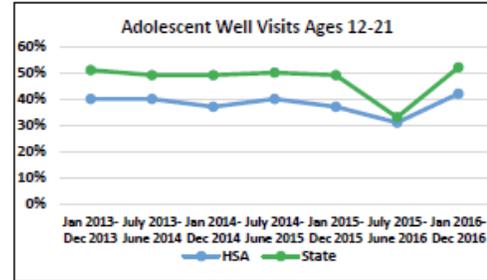
The University of Vermont Medical Center and the University of Vermont Medical Group are committed to being a national model for the delivery of high-quality academic health care for a rural region whose vision is working together, we improve people's lives. Its mission is to improve the health of the people in the communities served by integrative patient care, education and research in a caring environment.

Although the UVU Medical Center is known as Fletcher Allen Health Care, it serves a larger community. Ition people throughout Vermont and northern New York, the 2016 Community Health Needs Assessment (CHNA) considers the health needs of its primary health service area of Chittenden and Grand Isle counties in Vermont.

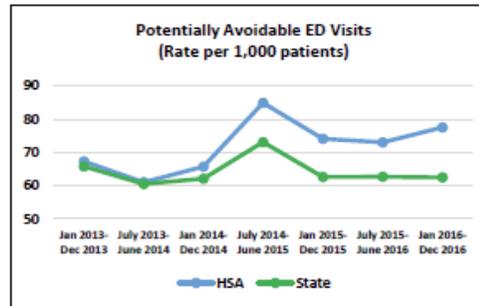
The partnership of the UVU Medical Center, the University of Vermont College of Medicine and the College of Nursing and Health Sciences forms Vermont's premier medical center. The UVU Medical Center serves approximately 170,000 residents in Chittenden and Grand Isle counties and provides primary care services at eleven Vermont sites.

This summary provides findings from the CHNA, a comprehensive review of health data and community input, health care relevant to Grand Isle and Chittenden counties. The assessment will be a large impact, but it is not complete analysis. We hope that this report will help individuals, organizations, and the community discussion and the creation of goals. We invite the reader to investigate and use the information in this report to move toward solutions for healthier communities.

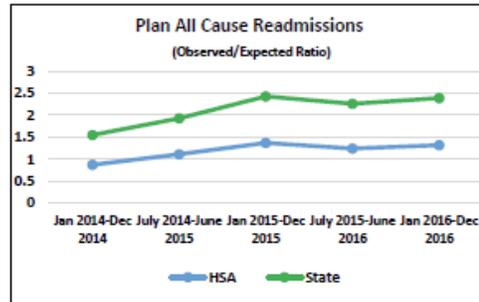
Organizations represented by the Morrisville UCC: Copley, Lamoille Home Health and Hospice, CHSLV, VDH, VCCI, The Manor, Agency of Human Services, Lamoille Housing/SASH, Hardwick Health, Medical homes, Lamoille County Mental Health, Lamoille Family Center, Recovery Center, Blueprint, OneCare Vermont, Health First, and Bi-State/Community Health Accountable Care.



**Measure:** Adolescent Well Visits  
**Population:** Patients ages 12-21 years of age  
**Definition:** The percentage of members ages 12-21 years, who had at least one well-care visit with a PCP or OB/GYN during the measurement year.  
**Data source:** claims, Blueprint HSA profiles  
**Noteworthy:** 100% of the medical homes are actively working on increasing adolescent well visits through panel management. This is also part of the Blueprint quality incentive PMPM payment.



**Measure:** Potentially Avoidable Emergency Department Visits  
**Population:** Patients ages 18 years older  
**Definition:** The number of ED visits by members per 1,000 patients that had a qualifying ICD code as a primary diagnosis.  
**Data source:** claims, Blueprint HSA profiles  
**Noteworthy:** This has been recognized as a problem in Morrisville HSA. The medical homes have attempted to tackle this problem for years, however, the recent addition of a Social worker in the ED is the most promising intervention.



**Measure:** Plan All Cause Readmission  
**Population:** Patients ages 18 years older  
**Definition:** Comparison of the rate of members who had an inpatient stay followed by an acute readmission for any diagnosis within 30 days during the measurement year to the expected rate of readmissions given risk factors of the patient.  
**Data source:** claims, Blueprint HSA profiles  
**Noteworthy:** The UCC focused on this measure for the past few years. Most recently, Copley hospital has been piloting a new screening tool to help identify patients at risk for readmission.

# Getting Started

What kind of dashboard will this be?

Operational \* Leadership \* Analytic

# Who is Your Audience / What Do They Need?

Ask them

What would you like to know?

What would you do if you knew this information?

# Finding the Right Data

Your priorities / locally meaningful

Standardized if possible

Accessible

Understandable

Actionable

# Design

“It’s beautiful if it optimizes the user’s ability to take in the information.”

# Case Study: Randolph

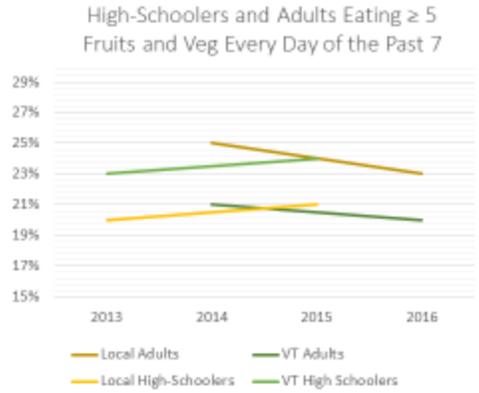
# Randolph Area Community Health Dashboard

2<sup>nd</sup> Quarter 2018

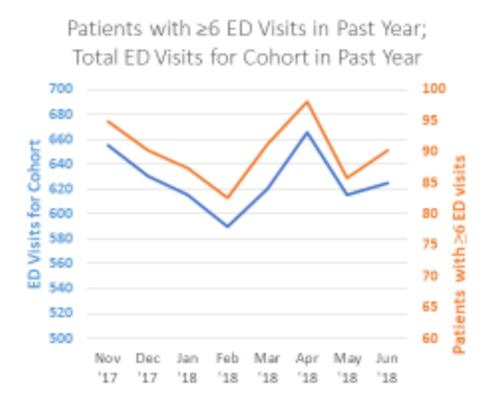
Dashboard developed by the Randolph Executive Community Council

About the Randolph Executive Community Council			
Randolph Executive Community Council Members: South Royalton Health Center, Gifford, Central Vermont Council on Aging, Capstone Community Action, Clara Martin, Community Health Accountable Care/Bi-State, Stagecoach, RACDC/SASH, VT Food Bank, Visiting Nurse and Hospice of VT and NH, Bayada, VDH, Randolph Area Opioid Response Team, DVHA – VCCI, Vermont Blueprint for Health, Green Mountain United Way, Orange Co. Parent/Child Center			
Population & Health Coverage	Local	Vermont	
	<a href="#">Blueprint Members, Randolph Hospital Service Area</a>	6,167 adults; 1,1715 ages 1-17	223,498 adults; 67,430 ages 1-17
	<a href="#">% Medicaid, Blueprint Members</a>	25.1%	21.9%
	<a href="#">% Medicare, Blueprint Members</a>	31.9%	27.8%
	<a href="#">Residents, Orange Co.</a>	28,974	623,657
	<a href="#">W/out health coverage, 18-64, WRJ</a>	6%	6%
	<b>RECC Team Functionality</b> Average Randolph Agreement 2015/2017 scored 1-5; 1 = strongly disagree, 5 = strongly agree		
<b>About the Local Population</b> For more census data, see the end of this document			

Measure	<b>FRUIT AND VEGETABLE CONSUMPTION</b>
Data Source	VDH: <a href="#">2014</a> and <a href="#">2015-2016</a> BRFSS, <a href="#">2013</a> and <a href="#">2015</a> YRBS
Population	Adults in the WRJ Health District; High-Schoolers in Orange County
Measure Definition	Self-reported eating of 5 or more fruits and vegetables every day for the last 7 days
Measure Leads	Emerging RECC Nutrition Workgroup
Community Goal	TBD in 2018
Improvement Strategy	TBD in 2018
Process Measures	TBD in 2018



Measure	<b>EMERGENCY DEPARTMENT UTILIZATION</b>
Data Source	Gifford Workgroup
Measure Definition	Patients with 6 or more visits to Gifford ED in past 12 months; total ED visits for this cohort of patients over past 12 months
Measure Leads	Care Coordination / ED Utilization Workgroup
Community Goal	TDB in 2018
Improvement Strategy	Gifford-Clara Martin team looking at who on list of ED high utilizers uses both organizations' services, then planning coordinated care management for cohort with aim of connecting them to preventative care that keeps them out of crisis.
Notes	Potentially Avoidable Outpatient ED Visits measure in Blueprint Profiles shows Randolph HSA at 69 per 1000 in 2016, vs. 63 VT average.



**Measure INITIATION AND ENGAGEMENT IN DRUG AND ALCOHOL TREATMENT**

**Data Source** [Blueprint HSA Profiles](#)

**Measure Definition** The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: initiation of AOD treatment through an admission, encounter, or visit within 14 days; engagement of AOD treatment including 2 or more add'l services within 30 days of the initiation visit. Measure is NQF #0004 defined [here](#)

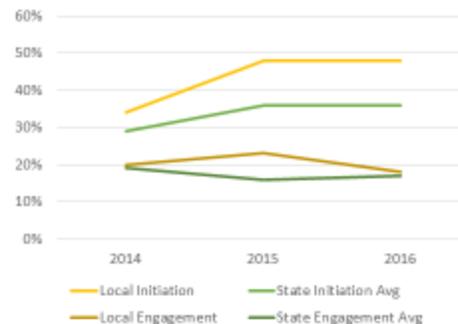
**Measure Leads** RECC will ask RAORT

**Community Goal** TBD in 2018

**Improvement Strategy** TBD in 2018

**Process Measures** TBD in 2018

Rate of People Initiating and Engaging in Alcohol or Drug Treatment Following a Diagnosis



**Measure DIABETES: HBA1C IN POOR CONTROL**

**Data Source** Gifford Quality Department

**Population** Gifford patients with diabetes, n 428 - 527

**Measure Definition** Percentage of diabetic patients age 18-75 who were seen at least once in the quarter and whose most recent HbA1c level was greater than 9% or not tested (within the past year). Excludes gestational diabetes and steroid-induced diabetes. See [NQF #0059](#). Comparison groups are from UDS dataset of FQHC patients (2017 data).

**Measure Leads** RECC Clinical QI Workgroup

**Community Goal** TBD in 2018 – current Gifford goal is <21%, Healthy People 2020 goal is 16.1%

**Improvement Strategy** QI Team at Gifford underway

**Process Measures** TBD in 2018

Diabetes Care HbA1c > 9% or Not Tested



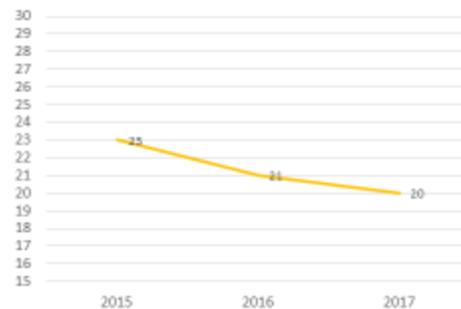
**Measure HOMELESSNESS**

**Data Source** [Vermont Statewide Point-in-Time Count](#)

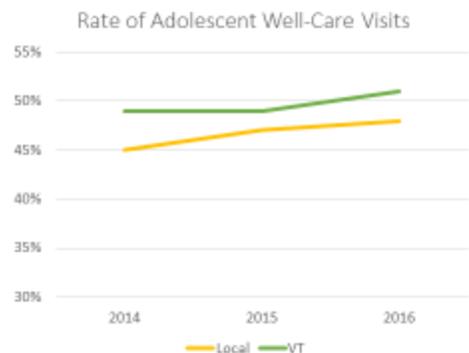
**Improvement Strategy** RECC monitoring only for now

**Process Measures** Consider Including Capstone Housing Opportunity Program clients stabilized; clients who remained stabilized after 90 days

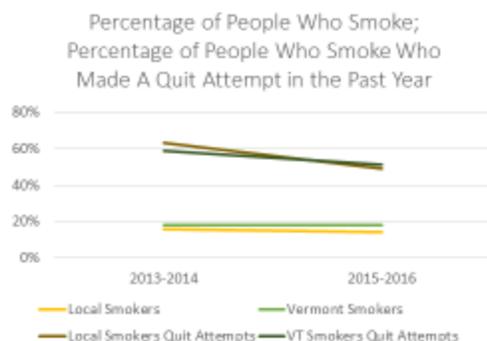
Number of Homeless People Orange County



Measure	<b>ADOLESCENT WELL-CARE</b>
Data Source	<a href="#">Blueprint HSA Pediatric Profile</a>
Population	Randolph Health Service Area pediatric population
Measure Definition	Proportion of members, ages 12–21 years, who received one or more well-care visits with a primary care practitioner or OB/GYN during the measurement year
Community Goal	
Improvement Strategy	
Process Measures	
Notes	Working to incorporate So. Royalton data into the measure, Bi-State QI project in 2016



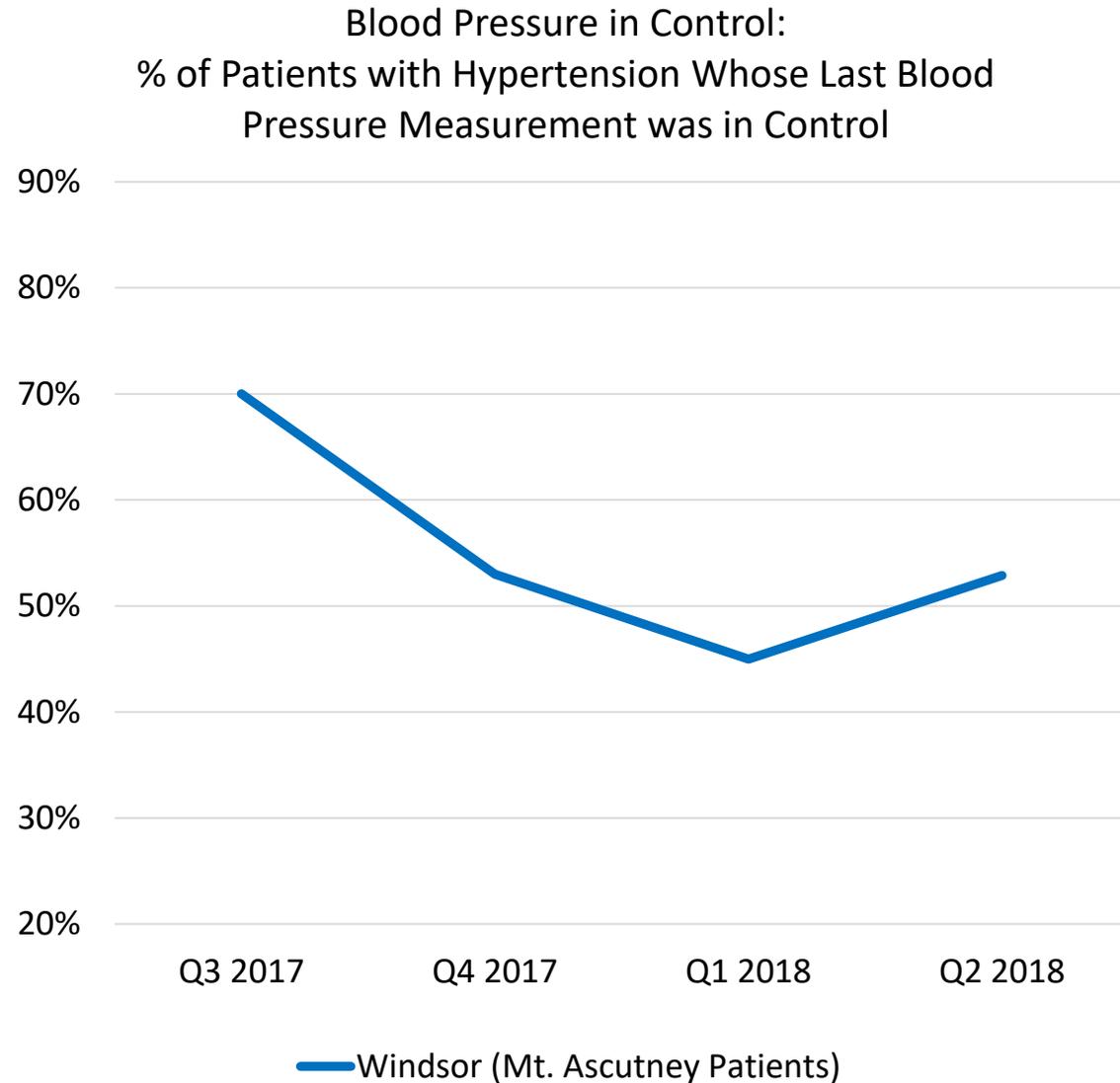
Measure	<b>SMOKING AND QUIT ATTEMPTS</b>
Data Source	VDH BRFS 2013-2014; 2015-2016
Population	White River Junction Health District
Measure Definition	Percentage of people who currently smoke and percentage of people who smoke who made a quit attempt in the past year
Measure Leads	Self-Management Programs Workgroup
Community Goal	TBD in 2018
Improvement Strategy	TBD in 2018
Process Measures	TBD in 2018



About the Population: <a href="#">Census Data for Orange County with Vermont Comparison Data</a>			
Measure	Time	Vermont	Orange County
Population estimate	7/1/17	623,657	28,974
Persons under 5 years, %	Accessed 6/14/18	4.9%	4.8%
Persons under 18 years, %	Accessed 6/14/18	19.0%	18.8%
Persons 65 years and over, %	Accessed 6/14/18	18.1%	19.2%
Female persons, %	Accessed 6/14/18	50.6%	50.0%
Race: white alone, %	Accessed 6/14/18	94.6%	96.8%
Veterans	2012-2016	42,848	2,326
High school graduate or higher, % of persons 25+	2012-2016	91.9%	91.7%
Bachelor's degree or higher, % of persons 25+	2012-2016	36.2%	30.2%
Persons with a disability, under age 65, %	2012-2016	10.3%	12.9%
Persons without health insurance (do not compare VT to county)	2016/2015	4.5%	4.8%
Median household income (in 2016 dollars)	2012-2016	\$56,104	\$54,263
Per capita income in past 12 months (in 2016 dollars)	2012-2016	\$30,663	\$28,691
Persons in poverty, % (do not compare VT to county)	2016/2015	11.9%	10.6%

# Case Study: Windsor

# Hypertension Care



## HYPERTENSION CARE: BLOOD-PRESSURE IN CONTROL

Measure Definition	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement quarter. Measure adapts NQF #0018 (definition <a href="#">here</a> ), using quarter instead of year.
Source	Local clinical data from Mt. Ascutney
Benchmark	The VT Blueprint aggregate blood pressure in control rate is 71% (using a year timeframe).
Community Goal or Process Measure	TBD
Notes	See the Vermont <a href="#">Hypertension Management Toolkit</a> for Hypertension QI tools

# Diabetes Care

## DIABETES CARE: DIABETES IN POOR CONTROL

**Measure Definition** The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement quarter was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement quarter. Measure adapts NQF #0059 (definition [here](#)) using quarter instead of year.

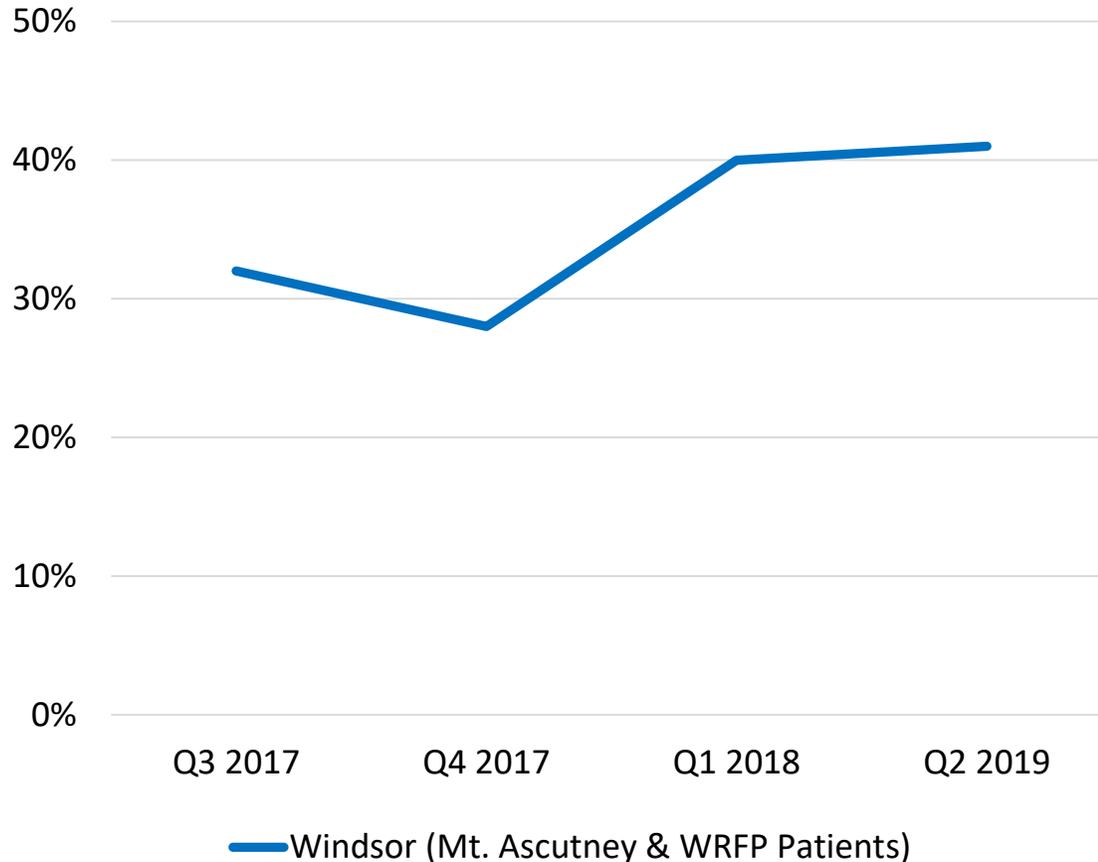
**Source** Local clinical data from Mt. Ascutney and White River Family Practice

**Benchmark** The VT Blueprint aggregate A1c in poor control rate was 12% in 2016 (using a year timeframe).

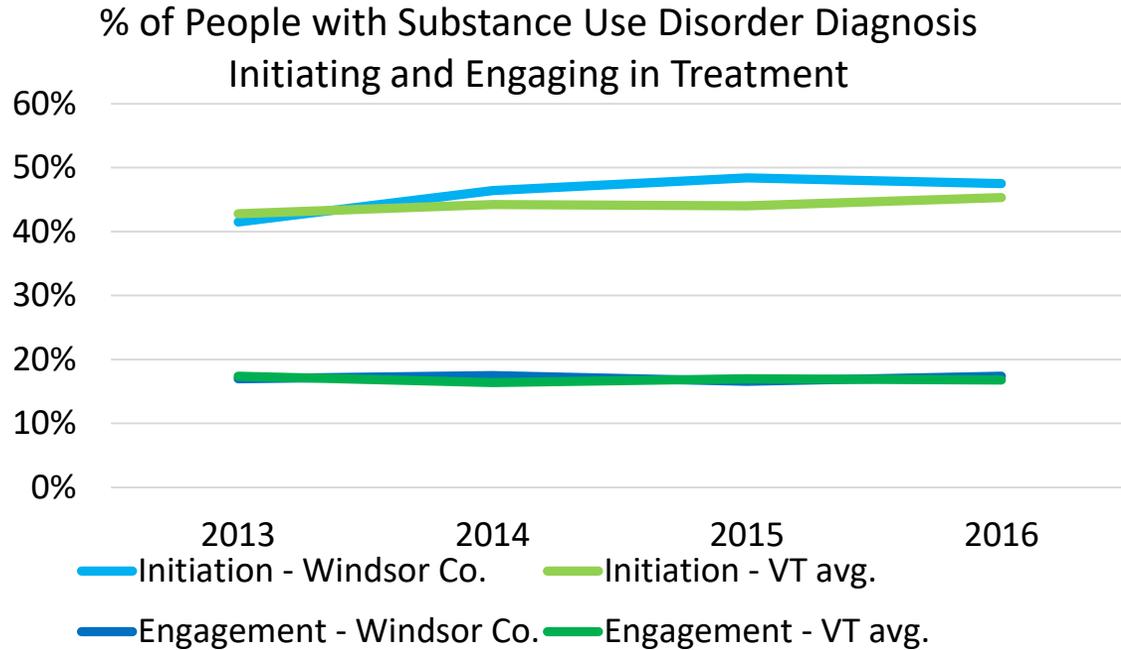
**Community Goal or Process Measure** TBD

**Notes** Dr. Levin is leading a quality improvement project at Mt. Ascutney, aiming to help patients with Diabetes improve their health.

HbA1C Not in Control:  
% of Patients with Diabetes whose most recent HbA1c level during the quarter was >9 or not tested



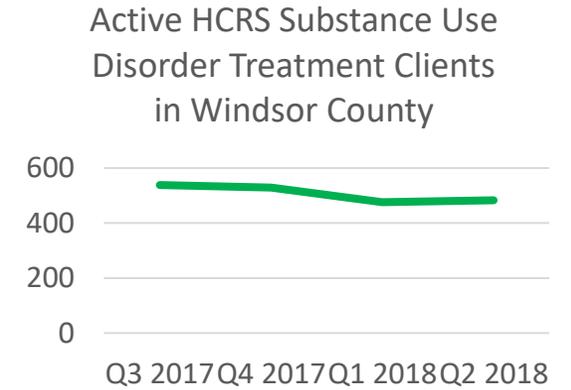
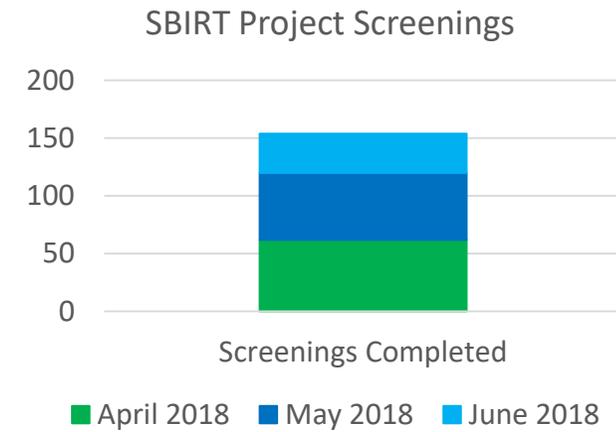
# Substance Use Disorder Treatment



**Measure Definition** The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: initiation of AOD treatment through an admission, encounter, or visit within 14 days; engagement of AOD treatment including 2 or more addl' services within 30 days of the initiation visit. Measure is NQF #0004 defined [here](#). Rates have been adjusted for Medication Assisted Treatment and Behavioral Health Residential Treatment.

**Source** Vermont Department of Health data

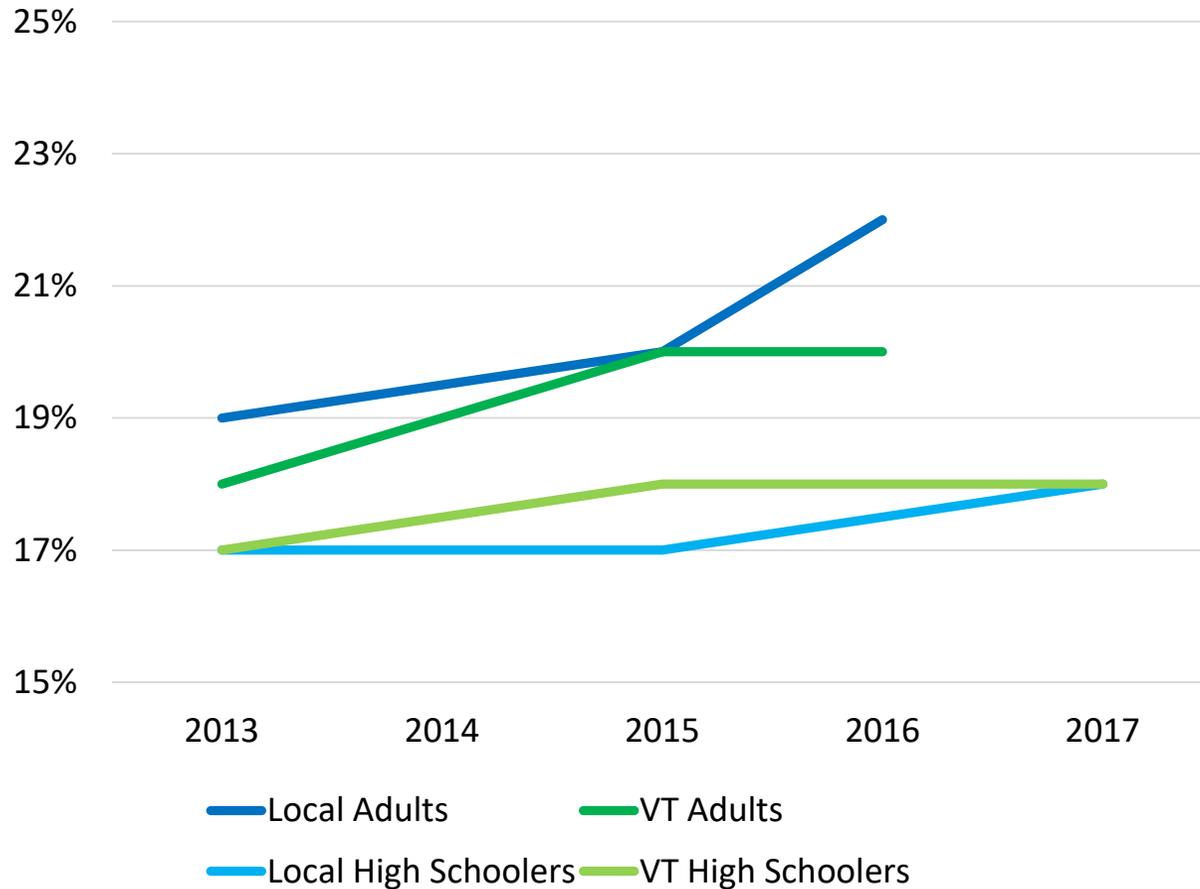
**Notes** Project underway building SBIRT into Emergency Department workflow through CHT staff, making referrals to treatment as needed.



Spoke Medication Assisted Treatment Resources, May 2018	
MDs prescribing	11
MDs prescribing to ≥ 10 patients	5
Staff FTE Hired	3
Medicaid Beneficiaries	224

## 3-4-50 Prevention Work

% of People Who Ate Vegetables  
3 or More Times per Day, Past 7 Days



### 3-4-50 Prevention

**Measure Definition**

Percentage of adults and high schoolers who report eating 3 or more vegetables each day of the last 7. Interaction with local prevention and healthy living initiatives will also be reported.

**Source**

VDH's [YRBS](#) for Windsor Co., [BRFSS](#) for White River Jct.

**Notes**

Shifted from fruit and vegetable consumption to vegetable consumption based on available YRBS calculations.

Cumulative Number of People Engaged by  
3-4-50 Outreach

